STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012730	A. BUILDING _____ B. WING _____	12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODVIEW HOME CARE LLC	3417 E STATE BLVD FORT WAYNE, IN 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS This was for a home health initial Medicaid survey. Based on the number of active patients listed, it was determined the agency did not meet the requirements of 7 active skilled patients at time of survey. The initial Medicaid survey was stopped on 12/13/12 at 1:35 PM. Census Service Type: Skilled: 2 Home Health Aide Only: 1 Personal Services Only: 1 Total: 4 Surveyor: Miriam Bennett, RN, BSN, PHNS On 12/12/12 at 0915, the surveyor entered facility. An entrance conference was concluded at 0940. At 10:05 AM, the facility indicated they only had 4 active patients but had 29 total since initial state survey in March, 2012. At approximately 3:00 PM, facility provided the Facility Census- Home Health form which indicated the agency only had 2 skilled patients. Supervisor notified 12/13/12 at approximately 8:30 AM and supervisor instructed to explain they did not have the required number of patients to continue with the survey. Facility notified at 10:55 AM of required number of active patients in order to conduct initial Medicaid survey. Employee F indicated they had been told they had to have 7 skilled patients since opening. The facility provided a list of 7 discharged skilled care patients. Two names on the list were Home Health Aide only, not skilled, patients. The agency and the Acute Care Supervisor had a discussion via phone at 1 PM. At 1:35 PM, the initial Medicaid survey was stopped as the agency	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 000	Continued From page 1 did not meet the requirements. Quality Review: Joyce Elder, MSN, BSN, RN December 18, 2012	G 000		